**Which Caregiver/Adult Was Involved (Client Name)?**

_____

**Date of Activity:** ____/____/____

**Program**

- Becoming a Mom
- Family Planning
- Maternal Child Health (MCH/M&I)
- Pregnancy Maintenance (PMI)
- Teen Pregnancy (TPTCM)
- Kansas Connecting Communities

## PHQ-9

| Over the last 2 weeks, how often have you been bothered by the following problems? | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired, or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed<br><br>Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead, or of hurting yourself in some way | 0 | 1 | 2 | 3 |
| **Totals** | | | | |

**Totals (of all boxes) =** _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

| Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

**Programs Providing Follow-Up: (select all that apply)**

- Becoming a Mom
- Family Planning
- Maternal Child Health (MCH/M&I)
- Pregnancy Maintenance Initiative (PMI) Teen Pregnancy Targeted Case Management(TPTCM)
- Kansas Connecting Communities (KCC)

**Was a brief intervention provided?**

- Yes
- No

**If yes, what brief intervention was provided?**

- Reviewed screening results
- Made clinical recommendations
- Provided education community, and/or treatment resources
- Measured patient-motivation and/or readiness to change
- Reinforced self-efficacy
- Other **Specify other intervention:**

_____

**Why was a brief intervention not provided?**

**Was a referral provided?**

- Yes
- No

**What provider type was client referred to?**

- Beacon Health Options
- Substance Use Treatment Provider
- Internal Mental Health Provider
- External Mental Health Provider CMHC
- External Mental Health Provider Private Practice
- MCO/MCO Care Coordinator
- Community-Based Support Group
- Primary Care Provider
- Other

**If other, please specify:** _____

**Why was a referral not provided?**

**Was the client in crisis?**

- Yes
- No

**If yes, what action was taken?**